Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
		IL6002059	B. WING		C 07/28/2020						
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE							
APERION CARE OAK LAWN 9401 SOUTH RIDGELAND AVENUE											
OAK LAWN, IL 60453											
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5)							
S 000	Initial Comments		S 000								
	Statement of Licens Complaint Investiga 2093052/IL122195										
S9999	Final Observations		S9999								
	Statement of Licens 2093052/IL122195	sure Violations			y i						
	300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.1210d)5) 300.3240a)										
	Section 300.610 Re	esident Care Policies									
	procedures governi facility. The written be formulated by a Committee consisting administrator, the a medical advisory conformation of nursing and othe policies shall complete the facility and shall	dvisory physician or the ommittee, and representatives r services in the facility. The y with the Act and this Part. shall be followed in operating be reviewed at least annually documented by written, signed									
		Medical Care Policies		Attachment A Statement of Licensure Violation	ns						
	h) The facility	shall notify the resident's									
linois Department of Public Health											

STATE FORM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

6899

V8YG11

TITLE

(X6) DATE

PRINTED: 10/05/2020 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					С		
		IL6002059	B. WING		07/28/2020		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STATE, ZIP CODE				
APERIO	N CARE OAK LAWN		TH RIDGEL N, IL 60453	AND AVENUE			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON.	(VE)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	CH CORRECTIVE ACTION SHOULD BE COMPLETE DATE		
S9999	Continued From page 1		S9999				
	physician of any ac change in a resider health, safety or we but not limited to, the manifest decubitus of five percent or m The facility shall ob plan of care for the	ccident, injury, or significant nt's condition that threatens the elfare of a resident, including, ne presence of incipient or ulcers or a weight loss or gain nore within a period of 30 days. Italia and record the physician's care or treatment of such change in condition at the time					
	Section 300.1210 Nursing and Persor	General Requirements for nal Care					
	care and services to practicable physical well-being of the re- each resident's con- plan. Adequate and care and personal of	shall provide the necessary to attain or maintain the highest al, mental, and psychological esident, in accordance with apprehensive resident care diproperly supervised nursing care shall be provided to each e total nursing and personal resident.					
	04' 000 4040	Our and Demoissant for	β.				
	Nursing and Person	General Requirements for nal Care					
	nursing care shall i	subsection (a), general nclude, at a minimum, the be practiced on a 24-hour, basis:	27.4 9.55				
	resident's condition emotional changes	bservations of changes in a n, including mental and n, as a means for analyzing and equired and the need for					

Illinois Department of Public Health

PRINTED: 10/05/2020 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING IL6002059 07/28/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9401 SOUTH RIDGELAND AVENUE **APERION CARE OAK LAWN OAK LAWN, IL 60453** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) S9999 Continued From page 2 S9999 further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1210 General Requirements for **Nursing and Personal Care** Pursuant to subsection (a), general d) nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour. seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection. and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect An owner, licensee, administrator, employee or agent of a facility shall not abuse or

Illinois Department of Public Health

neglect a resident.

These Regulations were not met as evidenced

PRINTED: 10/05/2020 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ C B. WING IL6002059 07/28/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9401 SOUTH RIDGELAND AVENUE **APERION CARE OAK LAWN OAK LAWN, IL 60453** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) S9999 Continued From page 3 S9999 by: Based on interview and record review, the facility failed to treat an open lesion on a resident's sacral region for four days for one (R1) of three residents reviewed for wound care in a total sample of seven residents. This failure of resulted in the delay of treating for four days of an open lesion progressing to a stage III pressure ulcer... Findings Include: R1 is a 78 year old with the following diagnosis: Alzheimer's disease and chronic obstructive pulmonary disease. R1 admitted to the facility on 2/20/20. The Minimum Data Set (MDS) dated 3/3/20 Section H documents R1 is frequently incontinent of urine and always incontinent of stool. Section M of the MDS dated 3/2/20 documents R1 is at risk for pressure ulcers with no interventions to prevent pressure ulcers in place. The Skilled Evaluation on 3/5/20 documents R1 has an open lesion to the sacral area. No documentation of any other staff notified about the new wound. The Skilled Evaluation on 3/6/20 documents R1 has a skin tear to the sacral

Illinois Department of Public Health

cm x 7.5 cm x 0.1 cm.

area. No documentation of any other staff notified about the wound. The Skilled Evaluation on 3/9/20 documents no wounds noted on R1.

The Wound Assessment Report dated 3/9/20 documents R1 has a sacral wound identified on 3/9/20 that is a stage 3 with measurements of 5

A Nurse Note dated 3/10/20 documents R1 with

V8YG11

PRINTED: 10/05/2020 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ C B. WING IL6002059 07/28/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9401 SOUTH RIDGELAND AVENUE **APERION CARE OAK LAWN OAK LAWN, IL 60453** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 4 S9999 an open area to the sacral region. The area was cleaned and dressed. On 7/23/20 at 11:58AM, V6 (LPN) stated, "I don't remember R1 having any wounds. We do weekly skin assessments on the residents. I would let the DON and wound care know if I found one." On 7/23/20 at 1:35PM, V7 (Wound Care Coordinator) stated, "R1 developed a pressure ulcer on the sacrum that was noted on the 9th. The wound was assessed to be a stage 3 pressure ulcer and the resident was placed on a low air loss mattress that same day." On 7/23/20 at 2:00PM, V7 stated, "I saw her on 3/9. When I am notified about a wound, I normally see them that day unless they find it over the weekend then I see them first on Monday. I see a resident for just about every type of wound when I am notified. I know R1 had a skin tear or something on R1's thigh then they found that wound on R1's sacrum and I treated it the day I was told about it. Yes, R1 is high risk for pressure ulcers. We are notified through a risk management form the nurse fills out. I never had a notification any sooner than March 9th for R1's wound. If it was there sooner and they were documenting on it then I wasn't notified about it." The policy titled, "Skin Condition Assessment & Monitoring- Pressure and Non-Pressure," dated 6/8/18 documents, "Caregivers are responsible

Illinois Department of Public Health

nursing progress notes."

for promptly notifying the charge nurse of skin breakdown. At the earliest skin of a pressure injury or other skin problem, the resident, legal representative, and attending physician will the notified. The initial observation of the ulcer or skin breakdown will also be described in the

PRINTED: 10/05/2020 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_\_\_ C IL6002059 B. WING \_ 07/28/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9401 SOUTH RIDGELAND AVENUE **APERION CARE OAK LAWN OAK LAWN, IL 60453** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 5 S9999 (B)

Illinois Department of Public Health